SANFORD
ORTHOPEDICS
SPORTS MEDICINE

Office-Based Concussion Evaluation

(For use in clinic setting)

Name:_____Referral Source: _____ N/A

DOB: _____Age: _____ Level of Education:_____School: _____

Date of Evaluation (Today's Date): _____Date of Injury: _____ Time Since Injury: _____

Person Reporting: ____ Patient ____Parent____ Spouse ____ ATC _____ Other _____

Cause: ____ MVA _____ Ped-MVA ____Fall ____Assault ____ Sport (specify) _____

___ Practice_____Game Position: _____ Mouthguard: Y / N Type: bite & boil custom

Mechanism of Injury: __Head to Head ___Head to Ground ____Head to Body Part _____ Other _____

Location of Contact:__ Frontal ____R / L Temporal____ R /L Parietal ___ Occipital____ Neck Other _____

Injury Description:_____

_____

Loss of Consciousness: Y / N Duration: _____

Amnesia (Retrograde): Loss of memory of events **before** the injury? Y / N Duration: _____

Amnesia (Anterograde): Loss of memory of events **after** the injury? Y / N Duration: _____

Early Signs: __Dazed or stunned___Confused or disoriented___ Answered questions slowly ___ Repeated questions __Forgetful

Seizures: Were seizures observed? Y / N **Same Day Return-to-Play** Y / N Describe:_____

Overall, how severe would you rate your problems with this injury? 0 1 2 3 4 5 6

Previous Provider: _____Date:_____ CT or MR Imaging ___ Yes___No Results: _____

Symptom Check List: Initial (day of injury) and Current (at the time of evaluation) – Rate severity on scale from 0-6

Physical (10)	Initial	Current
Headache		
Nausea		
Vomiting		
Balance problems		
Dizziness		
Visual problems		
Fatigue		
Sensitivity to light		
Sensitivity to noise		
Numbness/Tingling		
PHYS Total Score		
PHYS Total Symptoms		
TOTAL SCORE		

Cognitive(4)	Initial	Current
Feeling mentally foggy		
Feeling slowed down		
Difficulty concentrating		
Difficulty remembering		
COG Total Score		
COG Total Symptoms		
Emotional (4)	**Initial**	**Current**
Irritibility		
Sadness		
More emotional		
Nervousness		
EMO Total Score		
EMO Total Symptoms		
TOTAL SYMPTOMS		

Sleep (4)	Initial	Current	NA
Drowsiness			
Sleeping less than usual			
Sleeping more than usual			
Trouble falling asleep			
SLEEP Total Score			
SLEEP Total Symptoms			

Do these symptoms get worse with physical activity? Y / N / NA

Do these symptoms get worse with cognitive activity? Y / N / NA

Headache
Type: Throbbing/Pressure/Dull
Location: R or L Top/Frontal/Parietal/
Occipital/Generalized
Neck Pain? Y / N
Worse in AM / PM
Heachache worse with cognitive exertion? Y / N
Describe:

Headache worse with physical exertion? Y / N
Describe:

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Risk Factors for Protracted Recovery (Check all that Apply)

Concussion history Y / N	Development history	Psychiatric history	Headache history
Previous # 1 2 3 4 5 6+	Learning disabilities	Anxiety/Depression	Prior tx for HA
Longest symptom duration Days_____ Weeks_____ Months_____ Years_____	Attention-Deficit/ Hyperactivity Disorder	Sleep Disorder	History of migranes
If multiple concussions, did less force cause reinjury? Y / N	Other developmental disorder:	Other psychiatric disorder:	Family history of migraines or headache

Medications: _____

Other medical history: _____

Immediate Memory (Circle 'C' if correct, 'I' if incorrect)
I am going to read to you a list of words and, when I am done, repeat as many words as you can remember in any order. (Repeat process for trial 2 and 3).

List	Trial 1		Trial 2		Trial 3		Alternative Word Lists		
Elbow	C	I	C	I	C	I	Candle	Baby	Finger
Apple	C	I	C	I	C	I	Paper	Monkey	Penny
Carpet	C	I	C	I	C	I	Sugar	Perfume	Blanket
Saddle	C	I	C	I	C	I	Sandwich	Sunset	Lemon
Bubble	C	I	C	I	C	I	Wagon	Iron	Insect

	Normal	Abnormal
General appearance		
Describe:		

Motor and Balance	Normal	Abnormal
Fine movement of hands		
Finger-to-nose task		
Gait		
Tandem walk		
Rhomberg test		
Advanced balance testing*		

*Have athlete stand heel-to-toe with eyes closed, and hands on hips, for 20 seconds while trying to maintain stability (Non-dominant foot in back)

Concentration (Circle 'C' if correct, 'I' if incorrect)
I am going to read to you a string of numbers and, when I am done, you repeat them back to me backwards, in reverse order of how I read them to you. For example, if I say 719 you would say 917.

List	Trial		Alternative Number Lists		
4-9-3	C	I	6-2-9	5-2-6	4-1-5
3-8-1-4	C	I	3-2-7-9	1-7-9-5	4-9-6-8
6-2-9-7-1	C	I	1-5-2-8-6	3-8-5-2-7	6-1-8-4-3
7-1-8-4-6-2	C	I	5-3-9-1-4-8	8-3-1-9-6-4	7-2-4-8-5-6

Pupil / Eye Exam

Pupil appearance		Eyes	Normal	Abnormal
Dilated		Reaction		
Constricted		Horizontal motion		
Nystagmus		Unequal		

Delayed Recall (Circle 'C' if correct, 'I' if incorrect)
Do you remember that list of five words I read earlier?
Tell me as many words from the list as you can remember, in any order

List	Trial		Alternative Word Lists		
Elbow	C	I	Candle	Baby	Finger
Apple	C	I	Paper	Monkey	Penny
Carpet	C	I	Sugar	Perfume	Blanket
Saddle	C	I	Sandwich	Sunset	Lemon
Bubble	C	I	Wagon	Iron	Insect

Follow-up Plan

___ No follow-up needed, unless signs or symptoms return
___ Follow-up in clinic: Time until next follow-up _____
___ Referral to Sports Concussion Clinic
___ Other Referral
- ___ Neuropsychology
- ___ Neurology
- ___ Physical Therapy
- ___ Other: _____
- ___ Neurosurgery
- ___ Physiatry
- ___ Speech Therapy

___ CT / MRI
___ Emergency Department

Report Completed by _____

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